committee if the result is that their recommendations are not implemented.

The cover letter to the Prather document clearly states, quote, ''the White House is using the espionage angle to mask the real security risk which comes not from foreign spies, but rather from the Clinton administration's own ill-conceived strategy,'' end of quote. Of course the United States is a target of foreign espionage, including Chinese espionage. To ignore or fail to act on such evidence is an embarrassment to the Clinton administration, and it is dangerous.

Without the Cox Committee, we would still not know of this massive failure or be seeing corrective action. There is a significant difference between analyzing the motive behind whatever partisan spin and public relations angle the White House has given to the Cox Committee Report and the Prather analysis of the contents and conclusions of the report itself.

It appears to this Member that the Prather document mixes up these distinctions for its partisan purposes. In order to better support and prove its conclusions, the Clinton administration policy alone, and not any Chinese espionage, is responsible for American national security losses. The Prather analysis necessarily had to redefine the Cox committee report in a critical way. Unfortunately the overall credibility of the Prather document is suspect, given its numerous flaws and its noticeable selective cherry picking of the Cox committee report.

For example, the Prather document essentially dismisses the charge that China stole design information for the neutron bomb with the help of Taiwan-born Peter Lee.

This dismissal is based on a deliberately selective reading of our report, faulty assumptions and a disregard for other information which is still classified. The Prather document called this theft charge (quote) ''ridiculous'' (unquote) and opined that the Cox Committee, in its zeal to be bipartisan, claimed the Chinese stole neutron bomb information (quote), ''because the alleged spying happened on Reagan's watch, not Clinton's watch.'' (unquote). Notwithstanding Dr. Prather's interpretations, Peter Lee pled guilty to willfully passing classified U.S. defense information to PRC scientists and to providing false statements to a U.S. government agency.

The Prather document also introduces the case of Wen Ho Lee, another scientist at Los Alamos. In fairness, the Prather document states that ''Wen Ho Lee is not mentioned by name in the Cox Report . . .'' He is not. However, aside from the caveat, Prather treats the Wen Ho Lee case as if it was the lynchpin of our investigation. It was not and furthermore the allegations against Wen Ho Lee are, at this time, still just that—allegations.

This Member does not disagree with Dr. Prather that through our open system, smart people can gather significant amounts of information other countries would consider very sensitive. Mr. Speaker, our colleagues may recall the publicity that was given to the book ''Mushroom'' which was written back in 1978 by John Phillips, then an undergraduate student at Princeton University. Mr. Phillips wrote about how he was able to design an atomic bomb using only the open-source information available in the university's library. Experts confirmed the design was valid. This Member is sure that the Chinese and others have similarly used our open system, as Dr. Prather states. However, the detailed design plans and other extremely sensitive information relating to the neutron bomb and other thermonuclear warheads have not been declassified and are not in Princeton's library or on the Los Alamos public website.

There are numerous other instances in the Prather document of inaccurate interpretations and distortions of the Cox Committee Report for which there is not enough time this evening to detail. However, given the apparent political objectives of the Prather document and the questionable selectivity of its analysis, it should be seen for what it really is: a partisan attack or a partisan counterattack to a Clinton Administration selective leak and spin operation against the findings of the Cox Committee, and it therefore does not warrant any further attention.

Mr. Speaker, the Congress has just begun the job of implementing many of the 38 recommendations made in the Cox Committee Report. Most can be implemented by the executive branch without legislation. Some recommendations, such as increasing the penalties for export control violations, are relatively easy to legislate. Others such as reauthorizing the Export Administration Act, are not so simple and will take time and effort. This Member strongly urges his colleagues to concentrate on implementing these recommendations and not be distracted and dissuaded from this duty by those critics like the author of the Prather Report who all too apparently has a different agenda.

LT. COL. EILEEN COLLINS, FIRST FEMALE PILOT OF A SPACE SHUTTLE

The SPEAKER pro tempore (Mr. OSE). Under a previous order of the House, the gentleman from Texas (Mr. LAMPSON) is recognized for 5 minutes.

Mr. LAMPSON. Mr. Speaker, I rise this evening to talk about a first that is, in my opinion, long overdue. Early tomorrow morning, shortly after midnight, Lieutenant Colonel Eileen Collins, the first woman in the history of NASA, will command a 5-day Columbia space shuttle mission to launch NASA's most powerful space telescope, the Chandra X-ray Observatory.

Lieutenant Collins, who also can boast that she is the first female pilot of a space shuttle, is a good example of how far our space program has come since the first lunar landing 30 years ago tomorrow.

In these days of economic progress and budget surpluses, I urge all of my colleagues to support continued funding of the manned space program so that today's little girls can grow up knowing that they may be one of the first to walk on Mars or to conduct research in the international space station right alongside scientists from Italy, Russia, Japan, or wherever else in the world.

As a member of the House Committee on Science, and I guess a confirmed space nut, it makes me proud that I represent Johnson Space Center and its efforts to put more women into manned or, perhaps I should say, womaned space program.

Lieutenant Colonel Collins, I wish her Godspeed, a most successful mission, and a safe return for her and her crew.

HMO REFORM

The SPEAKER pro tempore. Under the Speaker's announced policy of January 6, 1999, the gentleman from Iowa (Mr. GANSKE) is recognized for 60 minutes as the designee of the majority leader.

Mr. GANSKE. Mr. Speaker, here we are again. Another week has gone by, and the House of Representatives, United States of America, has done nothing to address HMO abuses in this country.

Of course we had, Mr. Speaker, a big debate on the other side of the capital last week, and I want to talk a little bit about that, that bill that passed, because I think that my colleagues on both sides of the aisle will need to educate themselves on some of the details of that bill that passed the Senate last week.

I think we may be looking at that bill in the near future. I hope at least we will be looking at some bill on the floor in the near future. After all, it was about 2 weeks ago that the Speaker of the House told me personally that it was his intent to have HMO reform legislation on the floor by the middle of July.

Well, Mr. Speaker, I am looking at my dates here, and here we are, it is past the middle of July; and furthermore, we are going to find time this week to debate a tax bill and other bills, and there is nothing in sight to even be having a committee markup in the Committee on Education and the Work Force or in the Committee on Commerce on HMO reform.

It is not exactly, Mr. Speaker, like we have not been dealing with this issue for the last 3 or 4 years in Congress. It is not exactly as if earlier this year we were overworked here on the floor when we were naming post offices. Mr. Speaker, I think it is time that we get this issue to the floor. There are people that are losing their lives and losing their limbs and their health is being injured because HMOs are making medical decisions that are not in the best interests of their clients, their patients.

Mr. Speaker, I want to talk specifically about some of the provisions that are in Senate bill S. 1344, which passed last week in the Senate, because, Mr. Speaker, I have the bill here, and I have been reading through this bill, and you know, there is an old saying here in Congress: the devil is in the details. You can have awfully good headings, Mr. Speaker, but once you start looking at the language, you can find out that it comes up rather empty.

So let me just go over a few problems and deficiencies with the bill that passed the Senate last week.

Now a couple years ago we here in the House, the other body, passed a bill for Medicare and Medicaid recipients that was signed into law by President Clinton. It said that if you were having a chest pain, severe chest pain in the middle of the night such that a prudent lay person would say, hey, that could be a heart attack, you could go to the nearest emergency room and be treated, and your health plan would be responsible for covering the cost because we know from the American Heart Association that if you delay prompt treatment, diagnosis and treatment of a heart attack, you could be dead before you get your treatment; and unfortunately many HMOs have said, as my colleagues know, you could go to that emergency room, but if they find out that instead of having a heart attack that you just had a severe case of inflammation of your esophagus, for instance, well, that proves that you did not have a heart attack and we are not going to pay for it.

The problem with that, Mr. Speaker, is that once that information gets out, people are a little bit hesitant to go to the emergency room when they have crushing chest pain because they think, oh, my goodness, what if I am not having a heart attack? Then I could be left with thousands of dollars of bills. So maybe I will just be a little extra careful, and I will just stay at home here sweaty, really sick, until I am really sure that I have a heart attack.

Mr. Speaker, we wanted to fix that. We did that in Medicare and Medicaid. We passed what is called a lay person's definition of an emergency, and we told the Medicare health plans that you have to cover those services if a patient goes to the emergency room.

Mr. Speaker, you would think that it would not be too difficult to get the language right in a patient bill of rights that would apply to all Americans, the same as we have for those who are elderly in Medicare or those who are poor in Medicaid. After all, people are spending a lot of money for their health insurance, it ought to be worth something if one did wake up with that case of crushing chest pain in the middle of the night.

You would think it would not be too hard to simply take that language that we did in Medicare and put it into a bill that would apply to all Americans. That should not be difficult, should it? I mean, that is actually not one of the more contentious issues. But no, no, S. 1334, as reported, could not get that right either.

Let me give you an example. The bill fails to guarantee that health plans will cover emergency care at the nearest hospital. That should not be so difficult. If you do not take my word, just take my word for it and read Page 7, Line 1 through 20. The bill that passed the other body last week would allow plans to refuse to cover emergency services.

What are the details? Well, look at Page 8, Lines 3 through 7. The plan's obligations to pay for cost of treatment for stabilization, maintenance ends when the plan contacts the provider to arrange for discharge or transfer even if in the opinion of the treating physician the patient is not ready for transfer.

Or how about the provision that would allow plans to shift the cost of refusing to pay for emergency care to the health providers? That is Page 8, Lines 8 through 14. I mean, that should be a relatively noncontentious issue, but they could not get it right. They could not get it right. They had to write a bill that was an HMO protection bill for emergency provisions.

How about gag rules that HMOs have had in their contracts that say before you, the treating physician, can tell your patient all of his treatment options, you first have to get an okay from us, the health plan. Now think about that.

Now say a woman goes to her treating doctor, she has a lump in her breast. The doctor takes the history, the physical exam, and then he says, excuse me, leaves the room, has to get on the phone, phone the HMO and says, You know, I have Mrs. So and So. She has a lump in her breast, and she has three treatment options. I would like to tell her about all three treatment options.

And the health plan says, well, you know, according to our definition we only cover two of those, so we would rather not have you tell that patient about the third one because she might want it, might be appropriate for her.

Those are what are called gag clauses in contracts. Mr. Speaker, once again a couple years ago we passed a Medicare, a Medicaid rule that forbade those types of impediments to communications between their health care providers and their patience, doctors and nurses and their patients. We said you cannot do that in Medicare; you cannot do that in Medicaid. Not a big deal. It has not added really anything significant to the cost of premiums. But it is an important reassurance to patients so that they know they are getting the whole story.

Well, why could we not just take that language and put it into a bill that applies to all Americans? A bill that I have in the House here, the Managed Care Reform Act of 1999, does that; a bill that the gentleman from Michigan (Mr. DINGELL) has, Patient Bill of Rights, does that; a bill that the gentleman from Georgia (Mr. NORWOOD) has does that.

Could they get it right over in the other body? No, no. All they needed to do was add a few little words, but they are important words. They needed to add a provision that said all current contractual language prohibiting health communications is null and void. Could not do it. Could not force themselves to buck up to the HMOs on that.

Mr. Speaker, let me tell my colleagues what the two really big problems were with the bill that passed the other body last week, and that has to do with the definition of medical necessity and who gets to define that and whether you have an enforcement provision to make all of the other provisions in the bill mean anything.

Now, before I go into the language of S. 144, let me just set this up for my colleagues a little bit and tell them about testimony that a medical reviewer for an HMO gave before the Committee on Commerce.

□ 2145

It was May 30, 1996. A small nervous woman testified before the House Committee on Commerce. Her testimony came at the end of a long day of testimony about the abuses of managed care. This woman's name was Linda Peno. She had been a claims reviewer for several health care plans and she told of the choices that plans are making every day when they determine the medical necessity of treatment options.

Here is her story, quote: I wish to begin by making a public confession. In the spring of 1987, I caused the death of a man. Although this was known by my people, I have not been taken to any court of law or called to account for this in any professional or public forum. Just the opposite occurred. I was rewarded for this. It brought me an improved reputation in my job and contributed to my advancement afterwards. Not only did I demonstrate that I could do what was expected of me, I exemplified the good company reviewer. I saved the company a half a million dollars, unquote.

Well, it was clear to see her anguish over causing harm to patients as she testified. Her voice got husky. She continued, and the audience shifted uncomfortably and grew very quiet. The industry representatives and lobbyists who were there started looking at the floor and shifting their eyes.

She continued. Since that day, I have lived with this act and many others

eating into my heart and soul. For me, a physician is a professional charged with the care of healing of his or her fellow human beings. The primary ethical norm is, do no harm. I did worse. I caused death.

She continued. Instead of using a clumsy, bloody weapon, I used the simplest, cleanest of tools: My words. This man died because I denied him a necessary operation to save his heart. I felt little pain or remorse at the time. The man's faceless distance soothed my conscience. Like a skilled soldier, I was trained for that moment. When any moral qualms arose, I was to remember that I am not denying care, I am only denying payment.

She continued. At the time, that helped me avoid any sense of responsibility for my decisions. Now I am no longer willing to accept the escapist reasoning that allowed me to rationalize that action. I accept my responsibility now for this man's death, as well as for the immeasurable pain and suffering many other decisions of mine caused.

At that point, Ms. Peno described many ways that health care plans deny care, but she emphasized one in particular; the right to decide which care is medically necessary. She said, quote, there is one last activity that I think deserves a special place on this list, and this is what I call the smart bomb of cost containment, and that is medical necessities denials. Even when medical criteria is used by the health plan, it is rarely developed in any kind of standard traditional clinical process. It is rarely standardized across the field. The criteria are rarely available for prior review, review by the physicians or members of the plan, and we have had enough experience from history to demonstrate the consequences of secretive unregulated systems that go awry.

The room was stone cold quiet, and the chairman mumbled, thank you.

Well, Mr. Speaker, I wish that this were an isolated instance, but I can say what health plans are doing around the country. Under Federal law, under Federal law called the Employee Retirement Income Security Act, passed 25 years ago, employer health plans can define medical necessity in any way they want to. Let me give you an example.

There is a health plan in Texas that has defined medical necessity as the cheapest, least expensive care as determined by us, the health plan. Think about that. The cheapest, least expensive care as determined by us.

Well, Mr. Speaker, before I came to Congress I was a reconstructive surgeon. I took care of children who were born with birth defects, birth defects like cleft lips and palates. This is an anomaly that occurs in about one in 500 live births. The child is born with a big hole right in the middle of their face. Their lip is separated. They have a big hole in the roof of their mouth. It needs to be surgically corrected. That is the standard treatment, surgical correction.

But, Mr. Speaker, under Federal law, instead of a surgical correction of the roof of that child's mouth so that that child can learn to speak normally, so that that child does not have food coming out of their nose, that health plan, under their own contractual definition of the cheapest, least expensive care, under Federal law, could say, well, we are just going to provide a little piece of plastic, kind of like an upper denture, that will keep some of the food from going up. After all, that is the cheapest, least expensive care.

I do not think very many people in the public understand this. I do not think many people understand that by Federal law we have told HMOs that provide insurance under employer plans that they can determine any type of medical necessity they want, whether it meets prevailing standards of care, whether it has anything to do with the medical literature, whether it follows NIH guidelines, standard care for treatment, for cancer treatment. They do not have to follow it because they can write a little definition in their own health plan and under Federal law that is all they have to follow.

So I get back, Mr. Speaker, to the bill that passed the Senate last week, after a lot of partisan debate, but the underlying problem with that bill is this: I urge my colleagues to look at page 116 in the bill that passed the Senate, where it is dealing with external review where an independent panel could review denials of care.

What can that independent panel under that bill review? Items or services that would have been covered under the terms of the plan or coverage if provided by the plan or issuer. In other words, Mr. Speaker, they are just reiterating what current law is. They are saying that independent panel, which is looking at a denial of care that could be lifesaving for a patient, at the end of the day the only thing one can appeal is whether the plan has followed its own definition of medical necessity. That is not reform. That is why that bill ought to be called the HMO Protection Act.

I want to talk about something I have not talked about on the floor as it relates to this issue. This Congress may deal with an issue of physician-assisted suicide. There are people on both sides of that issue, but we have to remember what that debate is going to be like if we do not correct Federal law that says the HMO, in an employer plan, can decide what is medically necessary.

Assisted suicide is now legal in Oregon, and there exists a natural cost incentive for health plans to support assisted suicide over other more expensive treatment options, according to Nelson Lund, professor of law at George Mason University. He is an expert on assisted suicide.

Protecting patients from unscrupulous cost shifting is very difficult, he says Quote, it is very hard to think of a law that could make a distinction between legitimate cost cutting by an insurance company in long-term care and cancer treatments and an illegitimate cost reduction. Inevitably you have pressures develop. Unquote.

Insurance companies can exert an enormous amount of pressure on health systems as a whole and on individual physicians, Professor Lund says. Quote, once strong incentives are created through cost cutting, through the managed care system, you naturally are going to get more of the cheaper treatments and less of the expensive treatments. That has to be true. That is why things are done, unquote.

Mr. Speaker, although there are protections written into the Oregon law, I can guarantee that physicians will face subtle pressures to view patients' options as more limited than they otherwise may consider them. Lund says, quote, even though the law requires a diagnosis of less than 6 months to live, that is an incentive for the physician to say, this person only has 6 months to live.

Once eliminating the patient is considered a form of treatment, the economic incentives are there that I think are unstoppable, quote/unquote.

That is part of the reason why we have to change this Federal law. Look, it may cost an HMO only $500 to get an opinion that this patient should have a physician-assisted suicide. There is primary care referral. There is a mental health evaluation and there are the drugs. $500 is a lot less expensive than taking care of a patient with cancer towards the end of their life.

That is part of the reason why it is very, very important that this Congress, especially in the context of States looking at this issue of physician-assisted suicide, and I do not care whether one is on one side of the issue or the other side of the issue, nobody wants an HMO pushing providers to get rid of patients who may be expensive. That is why we need to have a definition of medical necessity, not determined by the plan as the cheapest, least expensive care but as something that would include looking at prevailing standards of care, looking at the medical literature, looking at NIH cancer treatment statements, consensus statements and, yes, looking at the health plan's own guidelines as long as they are peer reviewed.

All of those things should be taken into consideration, but none of them should be determinative and should not be determinative that the health plan, as under current Federal law, can simply say this is it. We do not care

whether someone can provide us with a table full of medical literature that says that that treatment is the standard of care and efficacious, because we did not define it that way.

Well, that is one of the main things that, unfortunately, the bill that passed the Senate last week did not address. It simply allows those health plans to go on even in the independent external appeals to define medical care however they want to.

What is the other big issue? The other big issue is whether those health plans should be responsible for those medical decisions that they make.

Mr. Speaker, let me just give you one example of how an HMO made a decision that resulted in a tragedy. A couple of years ago, a young mother was taking care of her 6-month-old infant. A little baby boy at 3:30 in the morning was really sick. He was hot, sweaty, temperature of 104.

Moms and dads can tell when their kids are really sick. So mom and dad thought he better go to the emergency room. So they phoned the 1–800 number for the HMO. They get a voice a thousand miles away who says, yes, I will let you go to the emergency room but I am only going to authorize this one emergency room, and the mother said, well, where is it? And the reviewing voice at the end of the line said, well, I do not know. Find a map.

Well, it turns out that it was a long ways away, 60 some miles away. Mom and dad wrap up little Jimmy, get in the car at 3:30 in the morning and start out on their trek.

About halfway through the trip, Jimmy is looking sicker, but mom and dad are not health care professionals. They do not know that they need to stop right away, but they do know if they did stop at an unauthorized hospital they are now stuck with potentially a very big bill. This family does not have that kind of resources. Most families do not have that kind of resources.

So they kept driving. They passed three emergency rooms that they could have stopped at. But they did not have an okay from the company. That company had made that medical decision, we are only going to allow you to go to that one hospital.

Well, about 10 or 15 miles from that hospital little Jimmy's eyes rolled back in his head and he stops breathing. Picture dad driving like crazy to get to the hospital, mom trying to keep little Jimmy alive.

They tear into the emergency room entrance. Mom leaps out of the car with little Jimmy, screaming save my baby, save my baby. A nurse comes out, gives him mouth-to-mouth resuscitation. They bring the crash cart out; they start the lines; they give him the medicines and somehow or another they get him back to life. That nurse blew the breath of life into little Jimmy again.

Well, he was a tough little guy and he managed to survive, but because of that delay by that medical decision by that HMO and that cardiac arrest with the loss of circulation, little Jimmy ends up with gangrene in both hands and both feet and they all have to be amputated.

Little Jimmy today is learning how to put on his bilateral leg prosthesis, with his arm stubs. His mom has to help him put on his bilateral hooks. He is getting along pretty good for a kid who has lost both hands and both feet, but he will never play basketball.

□ 2200

I would tell the Speaker of the House that he will never wrestle. I would say that someday, when he gets married, he will never be able to caress the face of the woman that he loves with his hand.

I hear the opponents of this legislation say, ''Ah, but these are just anecdotes. We do not legislate on the basis of anecdotes.'' I would say to them, this anecdote, if it had a finger, and you pricked it, it would bleed, if he had a hand.

Do my colleagues know what? Under Federal law, that health plan is liable for nothing other than the cost of the amputations. Can my colleagues believe that? It is the only industry in this country that has blanket immunity of that nature.

A judge reviewed this case. He determined that the margin of safety by that HMO for little Jimmy was, ''razor thin.'' I would add, as razor thin as the scalpel that had to amputate his hands and feet.

Now, I ask my colleagues on both sides of the aisle, many of us in the past, we have talked a lot on this floor about responsibility. When we were doing welfare reform, we said, ''Do you know what. If you are able bodied, you can go out and get a job, and you can support your family. That is responsibility. We will give you some education. But then it is your responsibility to support your family.''

There have been a number of times on the floor, this floor right here, where we have voted in a bipartisan fashion for the death penalty for somebody who has killed or raped one of our fellow citizens because we say that is responsibility.

I think people need to examine their hearts. Conjure up in your mind the goddess of justice, Themis. She is holding the scales. She is blindfolded. Under current Federal law, she has written across her chiton ''HMOs do not need to follow justice.'' We need to fix that.

There needs to be an enforcement mechanism. I looked at the Senate bill which passed last week, and do my colleagues know what the enforcement mechanism is? A $10,000 fine if it is found that the health plan followed its own definition of medical necessity. That is a joke. That is a travesty. To my colleagues, I say we need to fix that.

This will not result in a huge number of lawsuits. Texas passed a law, a good law. It had a strong external appeals process. It did make the health plans responsible in the end. Do my colleagues know how many lawsuits they have had? One. And one or two are pending in the 2 years, not that explosion of lawsuits. It has not resulted in an explosion of premiums. Texas premiums are below national average.

Before Texas legislature almost unanimously passed that law, the HMOs were saying, ''The sky will fall. The sky will fall. It will kill managed care in Texas.'' There were 30 HMOs in Texas at that time. There are 51 in Texas today. The President of Aetna described Texas today, after passing a strong patient protection law with liability provisions, he described Texas as the filet mignon, the filet mignon of States to have insurance in.

Mr. Speaker, I have given my colleagues a couple of examples tonight of some of the abuses of managed care that have resulted in terrible personal tragedies. Picture little Jimmy as your child or your grandchild, and tell me, when you examine your heart, if you think HMOs under Federal protection should be shielded from the consequences of their negligence. I do not think so.

Should we not have a strong appeals process, something that really means something so that an independent panel can determine medical necessity, not on the basis of some contorted contractual language definition that only serves the basis to increase the HMO's bottom line and profits?

That is what we are dealing with, Mr. Speaker. We are dealing with a bill that, on the surface, if one looks at the surface headings, is called a patient protection bill. But when one reads the fine print, it is an HMO protection bill. It is worse than the status quo in many ways.

I will be happy to share with my colleagues references, the page numbers, the line numbers of any of the statements I have made tonight. But I will tell my colleagues what, if this bill comes to the floor, and we bypass our committee process, then I think every citizen in the country should demand that their Representative know what they are voting on and that their Representative be accountable for improving the situation, not making it worse.

TOO MANY UNKNOWNS FOR ''PROJECTED'' SURPLUS

The SPEAKER pro tempore (Mr. OSE). Under the Speaker's announced policy of January 6, 1999, the gentleman from Tennessee (Mr. TANNER) is recognized for 60 minutes as the designee of the minority leader.